Statement of
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Under Secretary for Health
Department of Veterans Affairs
before the
Committee on Veterans' Affairs
U.S. House of Representatives
on the
State of VA Health Care

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Mr. Chairman and members of the Committee, I am pleased to be here today to discuss the challenges facing VA in meeting the current demand for VA health care services. As you know, the Secretary and I will be testifying before you on the President's FY 2004 budget request in less than 2 weeks. I will not be able to discuss the details of the budget request today.

Today's VA health care system is one of the most effective and successful health care systems in the Nation. VA's performance now surpasses many government targets for health care quality as well as measured private sector performance. For 16 of 18 clinical performance indicators, critical to the care of veterans, and directly comparable externally, VA is now the benchmark. This includes use of beta-blockers after a heart attack, breast and cervical cancer screening, cholesterol screening, immunizations, tobacco screening and counseling, and multiple aspects of diabetes care. These improvements don't just look good on paper; they save lives, reduce hospitalizations, preserve function, lower costs, and satisfy patients. By the way, VA is essentially identical to the best private sector health care performance on the last two indicators.

Our performance measurement program creates a framework for accountability, specifying the improvement we will achieve, not simply recording where we have been. The recent Institute of Medicine study entitled "Leadership By Example," lauded VA's approach to translating the best scientific evidence of research into increasingly effective patient care. Quoting from the study, "VA's integrated health care information system, including its framework for using

performance measures to improve quality, is considered one of the best in the nation."

VA's research program is specifically directed toward ensuring that the best science reliably informs our patient care, and that our research portfolio increasingly focuses on the clinical and health services research that specifically addresses the needs of Veterans. VA is widely recognized as a leader in such research areas as aging, women's health, AIDS, post-traumatic stress disorder, and other mental health issues. Our partnership with 107 medical schools and 1,500 other health professional training programs ensures that we bring state-of-the-art thinking to patient care. Conversely, as VA improves technologies such as computerization, advances accountability through measurement, and develops delivery models that better address patient needs, we improve health care for the country, as sixty percent of all health professionals, and 70 percent of physicians, experience some portion of their training in VA.

VA now has nearly 1,300 sites of care and provides health care services at locations much closer to where our patients live. Eighty-seven percent of VA's patient population now lives within 30 minutes of a VA medical facility. VA is providing care to nearly 48 percent more veterans than it did in 1997. At the same time, we have reduced the cost of care per veteran by 26 percent, not by cutting corners, but by delivering care more efficiently and more effectively.

Towards this end, VA is implementing management initiatives that will produce an unprecedented offset to the overall cost of the projected growth in workload and utilization. We have undertaken a rigorous competitive sourcing plan to determine whether commercial activities should be performed in-house using government facilities and personnel, or with private procurement processes. In addition, we continue to implement aggressive strategies to leverage our purchasing power, standardize equipment and supplies, ensure that any provider working part-time for VA provides services for every hour paid by VA, and maintain other management costs at or below 2003 levels. VA will also achieve efficiencies at the local level.

While transforming VA health care to a more efficient, effective, and accessible system, VA has become an industry leader in customer satisfaction, as is shown by its consistent benchmark-level scores on the American Customer Satisfaction Index, an econometric measure of government and private sector customer satisfaction. It is also noteworthy that VA medical facilities' average accreditation scores exceed those of private sector facilities.

VA continues to place a strong emphasis on comprehensive specialty care for which it has long been highly respected within the medical community, but we now also emphasize coordination of care through the universal assignment of primary care providers. With this transformation to a primary care delivery model, and by employing new models of care coordination and delivery, veterans have gained access to an integrated health care system, focused on addressing their health care needs before hospitalization becomes necessary.

In the past year, top leadership in DoD and VA created a Joint Executive Council that developed an overarching shared vision for the future and began to implement changes. The Departments have made unprecedented progress in sharing/coordinating medical care resources. Two President's priorities are jointly underway which will greatly enhance the seamless delivery of services to veterans – the information technology efforts on enrollment systems and electronic patient records. Many impressive collaborations have been made in other areas such as shared facilities and equipment, coordinated human resources, procurement, and other common business practices and training. We have shown significant progress and expect continued results as we coordinate the delivery systems beyond that experienced in the past.

The changes in the VA health care system have been profound, and the benefits have been recognized both inside and outside the Department. We provide better care to our nation's veterans, closer to their homes, and using the latest technology. However, we also face significant challenges, which we must meet to assure that our nation maintains a comprehensive, integrated health care system for all veterans who choose to come to VA for their care.

Resources and Demand

Because of the successes we have had in transforming VA health care and because of problems of coverage and availability of some services in the private sector, VA is experiencing an unprecedented demand for health care services. In FY 2002, VA enrolled approximately 800,000 additional veterans bringing the enrollment in the veterans health care system to nearly 6.5 million veterans. In FY 1996, VA provided care to 2.7 million veterans. In FY 2002, the number of veterans who received VA care increased to nearly 4.3 million. For FY 2003, we currently project that we will provide care to approximately 4.6 million veteran patients.

It is clear that continued workload growth of the magnitude we have seen in recent years is unsustainable. VA has been unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care. During the past year, the Secretary took steps to assure that VA would afford priority access to veterans with service-connected disabilities. He has recently announced additional steps that are necessary for the system to adequately serve all its patients and, in particular, to ensure that VA has capacity to care for veterans for whom our Nation has the greatest obligation: those with service-connected disabilities, lower-income veterans, and those needing specialized care.

Fully recognizing the extraordinary service that veterans have rendered to their fellow Americans, the Administration's budget for fiscal year 2004 will, we understand, seek a significant increase in VA medical care funding. As the demand for services from the Department continues to grow at a substantial pace, the Department must, of course, allocate its limited resources according to the priorities set by law. Accordingly, on January 17, 2003, the Secretary announced that, while it will continue to enroll veterans in the top seven priority groups that it serves, the Department must take steps to limit enrollment of new patients in Priority Category 8. Specifically, the Secretary has stated that the VA will enroll all priority groups of veterans, except those veterans in Priority 8 who

were not in an enrolled status on January 17, 2003, or who request disenrollment on or after that date.

To understand the wisdom of the decision to limit enrollment of certain persons in Priority Group 8, it is important to understand the Priority Group system established by law for the Department. Our priorities are as follows:

Priority Group 1

- Veterans with service connected disabilities rated 50% or more disabling.

Priority Group 2

- Veterans with service connected disabilities rated 30% - 40% disabling.

Priority Group 3

- Veterans who are former POWs.
- Veterans awarded the Purple Heart.
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty.
- Veterans with service-connected disabilities rated 10% or 20% disabling.
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation".

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits.
- Veterans who have been determined by VA clinicians to be catastrophically disabled.

Priority Group 5

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds.
- Veterans receiving VA pension benefits.
- Veterans eligible for Medicaid benefits.

Priority Group 6

All other eligible veterans who are not required to make co-payments for their care, including:

- World War I veterans;
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
- Compensable 0% service-connected veterans.

Priority Group 7

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and income below the VA's Geographic Means Test.

Priority Group 8

- Veterans who agree to pay specified copayments with income and/or net worth above the VA Means Test threshold and the VA Geographic Means Test threshold.

Thus, it is clear that the decision regarding limitation of enrollment of certain persons in Priority Group 8 reflects a sound application of limited resources to priorities.

Let me emphasize that those in Priority Group 8 who were enrolled prior to January 17 are not affected by the limited enrollment decision and may continue to receive health care from VA.

We believe that the difficult decision to limit enrollment of certain persons in Priority Group 8 had to be made in order to maintain the quality of the health care we provide to currently enrolled patients and those higher-priority veterans who have yet to enroll. It will allow the VA to refocus the mission of the

healthcare system and rebuild the capacity of the system to provide for the tertiary care and special needs of the service-connected, low income, and special needs veterans, as well as future veterans who may suffer significant disability resulting from combat service.

On a related point, the Secretary has announced that work is underway with the Department of Health and Human Services (HHS) to determine how to give Medicare eligible Priority Group 8 veterans who cannot enroll in VA's health care system access to a "VA+Choice" Medicare plan. To accomplish this, VA could contract with a Medicare+Choice organization, and eligible veterans would be able to use their Medicare benefits to obtain care from VA. Additional details will be forthcoming as we work out the details of this approach. We are hopeful that the "VA+Choice Medicare" plan will become effective later this year.

Waiting Lists

During much of the past year, we had over 300,000 patients on waiting lists to receive medical care. Currently, about 201,000 veterans are on waiting lists. It should be noted that these numbers are not static. New enrollees join the list, even as enrollees come off of the waiting list to become new patients in the system. While the enrollment decision will serve to reduce the number of veterans who will be allowed to enroll in the VA health care system, we must continue our efforts to reduce and eliminate excessive waits. VA has made a concerted effort to reduce waiting times and is fostering multiple efforts including:

- Developing the Advanced Clinic Access (ACA) initiative in collaboration with the Institute for Healthcare Improvement: The core of ACA is a training program that provides strategies and change concepts to assist clinic staff make their processes more efficient to reduce wait times, improve access, and decrease costs.
- Developing a national Waiting Times Web Site and computerized wait list and scheduling package: This effort enhances measurement of wait times for every patient seeking access to VA services and improves scheduling, efficiency and effectiveness, and

- Developing monitors to identify the percent of active patients assigned to primary care providers and the percent of primary care provider capacity that is utilized by active patients.

Despite all of these efforts, we now must recruit additional primary care and specialty provider staff in order to keep pace with the current demand for care and assure our ability to meet the comprehensive needs of the veterans we serve.

Improved Health Management

Although our efforts to reduce waiting times have been highly successful, we must continue to find better ways to deliver health care. Historically, health care in this nation has been managed from the perspective and needs of the provider. As a hospital system, we waited until veterans required hospital care. Even now, we schedule appointments based on the provider's best guess of when the patient will need to be seen and when an appointment might be available, not based on when the patient actually requires care. We're not alone; this is the approach taken by most health care systems today. However, we believe that better health care management strategies are now possible.

We must find new ways to partner with patients to more effectively manage health and disease processes continuously, 24 hours a day, 365 days a year. We need to be able to see the patient "just in time" when a complication or need starts to develop. This shift constitutes a fundamental change in how we view health care and this approach will have a groundbreaking impact on both primary care and long-term care. While the impact on primary care and the management of many chronic conditions will be substantial, the impact on long-term care will be even more profound, especially as we are a system that will experience a 200 percent increase in veterans over 85 years of age by decade's end.

Institutional long-term care is very costly and may impair a long-term spousal relationship and reduce overall quality of life. Long-term care should focus on the patient and his or her needs, not on an institution. The technology

and skills exist to meet a substantial portion of long-term care needs in non-institutional settings.

In those situations where long term care in the veteran's home is not practical, assisted living facilities may meet the needs of veterans and their spouses. The VA recognizes that assisted living facilities are used in the private sector as a lower cost alternative to institutionalization, and more importantly, as an option which keeps the pair bond between the husband and wife intact, providing a higher quality of life. VA currently is operating an assisted living pilot project and will evaluate the significant impact of the pilot in terms of quality of care, veteran satisfaction, and cost.

VA must leverage its leadership in computerization and advanced technologies to better provide patient-centric care. Technology is increasingly available to provide the limited health care that is needed to support long-term care for many veterans in their homes or in assisted living facilities. Technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor various health status indicators in the patient's home, such as blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure. With tele-health support, many of our nation's veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. Nursing home care should always be the option of last resort, where it is medically infeasible or inadvisable for a veteran to receive care at home or in an assisted living facility.

To oversee many of the initiatives needed to implement a patient-centered model for primary and long-term care, I have instructed creation of a Care Coordination Office. Although the final responsibilities of this office are still under consideration, it will have in its charge such things as the use of technology in care coordination and the development and implementation of policy and initiatives in chronic disease management and long term care.

But while there is much that VA can do on its own, there are also legislative impediments that need to be addressed. First, we must revisit the

long-term care capacity provisions implemented by the Veterans Millennium Health Care and Benefits Act (Millennium Act). Currently, only VA-operated and VA-staffed extended care programs may be considered for purposes of meeting the capacity requirement for institutional and non-institutional extended care. For more than 30 years, however, VA has developed a continuum of institutional and non-institutional services to meet the extended care needs of veterans, including VA-provided, contracted, and State home-provided services. In FY 2002, for example, approximately 70 percent of VA's institutional nursing home care occurred in contract community and State home nursing homes. Also in FY 2002, approximately 37 percent of VA's total extended care patient population was served in non-institutional settings. The availability of these programs has improved access and created choices for veterans who have family and social support systems far from VA nursing home facilities. As a result, the quality of remaining life in this group of veterans has increased significantly. I believe that the capacity requirement should better reflect VA's current direction in the provision of long-term care.

Recruitment and Retention

To work down the waiting lists, and to continue to provide the quality and safety our veterans deserve, and to provide care with the efficiency that the budgetary environment demands, we need to be able recruit and retain appropriate health care professionals. National nursing leaders and health care organizations are projecting a shortage of registered nurses that will be unlike any experienced in the past. The current and future numbers of professional, registered nurses may be insufficient to meet our national health care needs. At the same time, changes in health care delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community. VA expects to face increasing challenges in maintaining its nursing workforce and we must remain competitive in pay and workforce innovations.

VA is also facing a critical situation in which its compensation system for physicians and dentists is unresponsive to the demands of the current market. The effect of noncompetitive pay and benefits is seen in dramatic increases in VA's scarce-specialty, fee-basis, and contractual expenditures. In addition, the short supply of some clinical subspecialties in the medical community is causing rapid increases in salaries, benefits, and perquisites. VA's special pay authorities have not been revised since 1991. VA's current pay authorities are stretched to the maximum, and the Department can no longer offer competitive salaries for these medical sub-specialists. More importantly, the current statutory compensation structure does not offer a way for VA to link physician and dentist compensation to quantitative and qualitative outcomes.

We are currently developing a comprehensive workforce improvement proposal that would improve our ability to recruit and retain physicians, nurses, and other health care occupations. The Administration expects to submit this proposal by late spring of this year. This proposal will be vital to our ability to recruit the additional providers needed to increase our capacity, eliminate waiting lists, and refocus on our core mission of comprehensive care for service connected, low income, and special needs veterans.

Mr. Chairman, the current state of VA health care is excellent, but we still have much to do to maintain that excellence and build upon it in order to provide the right services, at the right time, and in the right place to the veterans of the 21st century. My vision of the future of VA health care is positive, but to realize that vision, we must address head-on the challenges I have outlined and do so deliberately, or we risk a different future.

This concludes my statement. While I cannot answer any specific questions regarding the content of the FY 2004 President's Budget that will be released next week, I will now be happy to answer any other questions that you and other members of the Committee might have.